MENTAL HYGIENE IN INDIANA

State of Indiana
Department of Public Welfare
141 South Meridian Street
Indianapolis, Indiana


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MENTAL HYGIENE IN INDIANA

Division of Medical Care
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Director

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THE PROBLEMS OF MENTAL ILLNESS AND MENTAL DEFICIENCY

Introduction

The Human Tragedy

Amid all the ills that beset human beings, none is more tragic than derangement of the mind. No physical disease is more incapacitating, for when the mind is gone the one quality which is distinctively human is swept away. None is more disturbing to the loved ones of the afflicted, for in place of the man that was, with his wit, his personality, his memory and all its associations, stands a stranger, unpredictable and unreal. Shunned and feared by his former associates, he is protected and sheltered by his family, who, in turn, avoid their friends in shame. A pall of gloom is cast over that household where one of its members is cut off from reality by derangement of the mind. Such is the fatalistic attitude adopted by the vast majority of the public toward mental disorders.

Actually, control over mental disease is increasing with the development of newer methods of treatment, and prevention now is practiced both by treatment of cases before complete mental collapse and by continued emphasis upon the factors which make for mental health. Yet the surface has hardly been scratched so far as prevention is concerned. One of the greatest stumbling blocks is getting the public to change its fatalistic and condemnatory attitude toward mental disease. First and foremost, mental illness is a disease, different only in its manifestations from any physical illness. To many persons, however, mental illness is something remote and fantastic. They have had no first-hand contacts with persons so afflicted. They know nothing of the tragic consequences that flow from mental disorder. Consequently, they are likely to minimize the importance of this type of disorder.

The Numerical Importance of the Problem

If mental illness were confined to a relatively few individuals, even the seriousness of the disease to those individuals and to their immediate families might be passed over lightly when dealing with the varied troubles that beset the life of man. Unfortunately, such is not the case. Mental illness is much more prevalent than most persons suspect. Throughout the nation, more hospital beds are devoted to the care of the mentally sick than to the care of all other classes of hospital cases combined. There are almost half a million persons in public mental hospitals in the United States, and the number of patients in such hospitals is rising at the rate of approximately 14,000 a year. Thus, in the United States there are about four persons in such institutions for every 1,000 persons in the general population. Alarming as these figures are, there is no reason to believe that mental disease is on the increase. The increase in mental hospital population simply reflects a growing awareness of the problem and a willingness to provide more adequate hospital accommodations.

Studies have been conducted in various parts of the country to show how many persons may be expected to suffer from mental illness. One such study made in New York state revealed that approximately 4.5 per cent of the persons born there may be expected to succumb to mental illness in one form or another and to become patients in hospitals for such disorders. In other words, about one person out of every 22 born in New York state will become a mental patient at some time during his or her life.

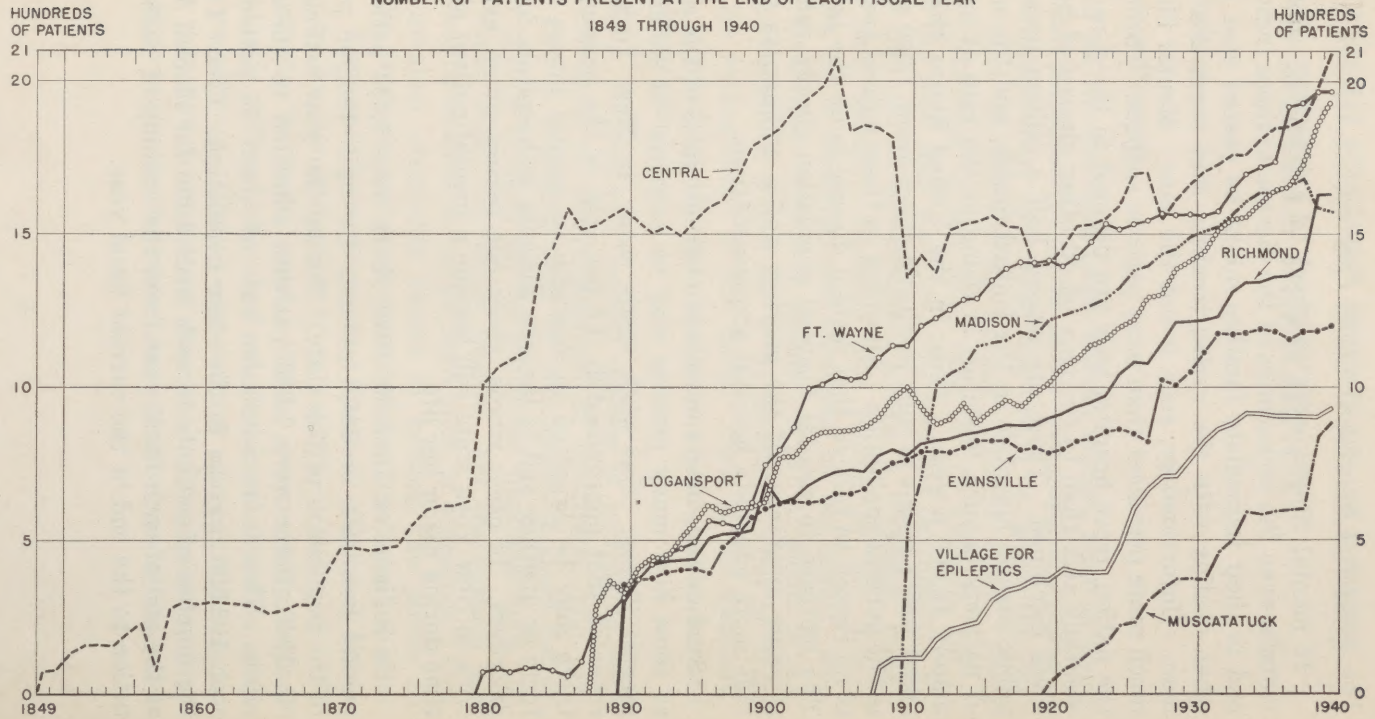
In Indiana, on June 30, 1940, there were 8,433 patients in mental hospitals, or 246.8 patients for each 100,000 persons in the population of the state. During the year ending June 30, 1940, there were 1,928 patients admitted to these hospitals. This is an admission rate of about 56 patients for each 100,000 persons in the state population. Chart I shows the number of patients in each institution for mental disease at the end of each fiscal year from the opening of each institution to the end of the current fiscal year.

CHART I

INSTITUTIONS FOR MENTAL CASES

NUMBER OF PATIENTS PRESENT AT THE END OF EACH FISCAL YEAR

1849 THROUGH 1940



It will be seen that the number of mentally diseased patients in state hospitals in Indiana has steadily increased from 1849 to the present year. Likewise, the trend of admissions has been on the increase since the establishment of the various state hospitals. The following chart shows the number of new admissions to the mental hospitals in Indiana, year by year, since the establishment of each institution.

Over the past ten years, the average number of new admissions each year to the mental hospitals of the state was 1,595. The average daily population of these hospitals over the same period was 7,649. There is a complete turnover of the population of the mental hospitals in the state once in about four and a half years.

The Mentally Ill and the Mentally Deficient

Considerable confusion exists in the minds of many persons as to the difference between mental illness and mental deficiency. Mental illness is derangement of a mind which had previously functioned more or less normally. Mental deficiency, or feeble-mindedness, is a lack of intelligence, evidenced from an early age, which is either the product of heredity or the result of arrested mental development because of disease or injury. Because the problems created by these two types of mental disorder differ widely, each will be discussed separately.

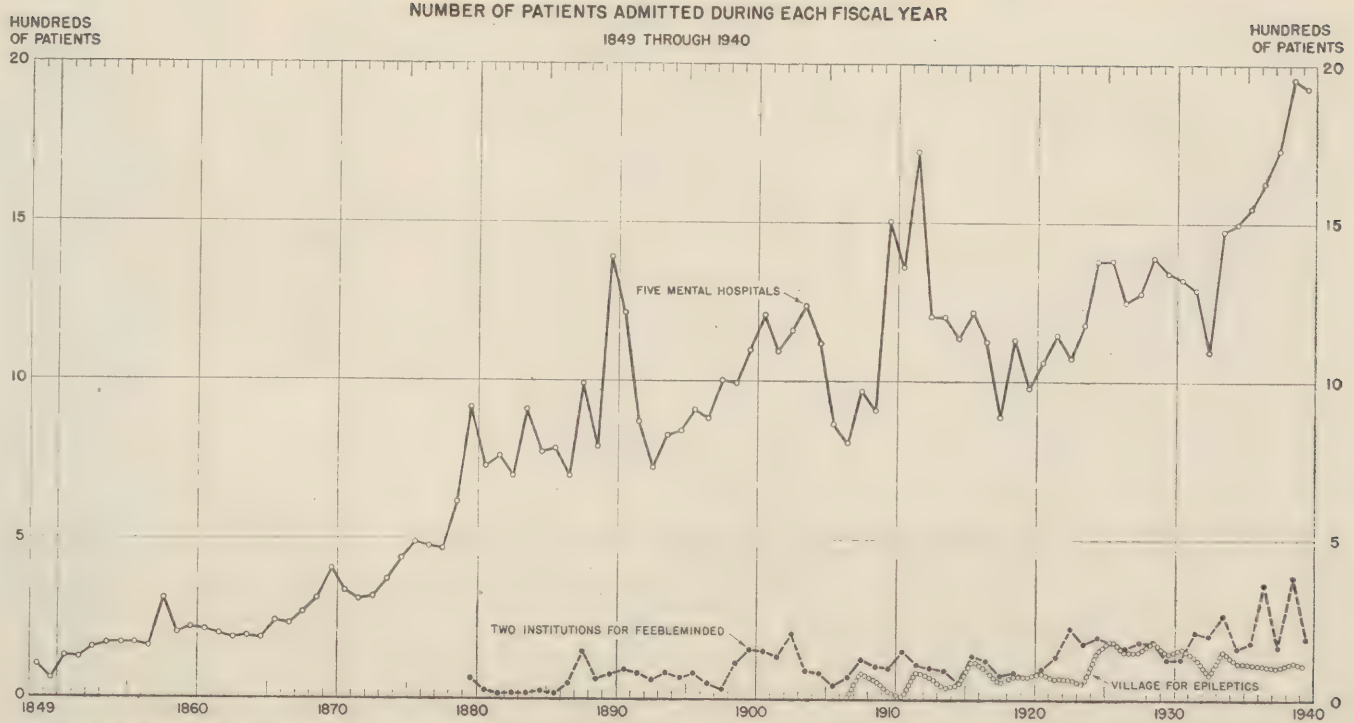
Madison State Hospital, "Cragmont", is the last of the five hospitals established by the state for the care and treatment of mental cases. The 30 principal buildings house more than 1,600 patients.

CHART II

INSTITUTIONS FOR MENTAL CASES

NUMBER OF PATIENTS ADMITTED DURING EACH FISCAL YEAR

1849 THROUGH 1940



THE LEGISLATURE OF 1933 CHANGED THE FISCAL YEAR TO END JUNE 30 INSTEAD OF SEPTEMBER 30. THE DATA FOR THIS YEAR, THEREFORE, COVER BUT NINE MONTHS.

The Mentally Ill

Definition

In the past, persons suffering from mental illness were grouped together under one term, the "insane". Today the use of this term is discouraged, partly because of the odium which attaches to it and partly because it is more properly a legal instead of a medical term. Strictly speaking, we ought to refer to mental diseases rather than to mental disease, for mental disorders constitute a class or group of diseases. In the more serious types of mental disorder, known technically as psychoses, there are at least a dozen distinctly recognizable forms, some described in terms of their symptoms, others described in terms of their cause. On the other hand, there are less serious types of mental illness ranging all the way from psychoneuroses to the malajusted personality. In fact, there is a school of thought which regards psychotic persons merely as cases in which the traits and tendencies exhibited in disordered personalities are carried to such extremes as to make these individuals unfit for social intercourse.

Early Treatment of the Mentally Ill

The history of the care of the mentally ill does not present a pleasant picture. Identified with notions of demonology, the insane were from a very early time thought to be possessed of evil spirits. Their disorders thus diagnosed, their treatment consisted of exorcising these demons by such methods as were available to the representatives of the religion of the day. The tenacity with which such an idea persists is witnessed by the fact that this notion is still current today among some religious sects. But what is more important is the still widely prevalent attitude, derived from this notion, of fear of the insane.

When treatment of the insane passed from the hands of the clergy, their lot was not greatly improved. When removal from society became necessary, they were housed in jails and poorhouses. Shackled hand and foot, they were left to rave until such time as death delivered them from their misery. Toward the close of the eighteenth century,

the problem of housing such persons became so acute in this country that a beginning was made by the erection of buildings expressly for the purpose of keeping the insane. Throughout the nineteenth century, there was an era of building these "madhouses" by the counties, towns and cities.

The first American institution designed solely for the housing of mentally ill patients was opened at Williamsburg, Virginia, in 1773. Not only was this the first institution of its kind in this country, but it remained the only state hospital for the insane in America for a period of fifty years. It is doubtful, however, if anything more than custodial care was given patients even in this institution.

In 1821, the Bloomingdale Asylum was opened as a separate unit of the New York Hospital, and the opening of this institution marks a turning point in the treatment of the mentally ill. Founded through the initiative of Thomas Eddy, a Quaker philanthropist, it was probably the first institution for the insane in America operated primarily on therapeutic principles.

Spread of this conception of the care of the mentally ill was slow indeed. A century ago, there were in the entire country nine asylums or hospitals for the insane, seven of which were supported in whole or in part by state funds, founded upon what has been called the "cult of curability". The fundamental belief of members of this "cult" was simply that mental disease is first and foremost a disease and is curable—truly a radical departure from current thinking on the subject. Members of this group labored to put their theory into practice by developing new methods of treatment of the insane. Half a century passed and little progress was made in converting new followers to this point of view. In the fifty years, however, other changes did take place. This period saw the fruits of the crusade of Dorothea Dix. By the time of her death in 1887, directly as the result of her efforts, 20 states had established or enlarged their mental hospitals.

By the turn of the twentieth century, the insane were housed in elaborate buildings called "hospitals". They were, for the most part, removed from jails and almshouses; they were segregated in institutions designed especially for the

care of the mentally ill. Unfortunately, the expansion of the "cult of curability" did not keep pace with the development of mental hospital building. Many of the old methods of care were carried over into these new institutions in slightly modified form—chains, strait jackets and padded cells. Frequently these new institutions were operated by men who had no scientific notions of mental disease, who regarded their task as custodial in character and their function as that of caring for the animal needs of their patients and seeing that they did as little damage to themselves and to others as possible.

Several factors operated to retard the progress in the care and treatment of the mentally ill which looked so promising before the end of the nineteenth century. By about the middle of this century, the practice of nonrestraint was widely adopted in England. This meant that the use of mechanical means for restraining disturbed patients, such as the use of chains and fetters, was discarded by many of the institutions in England. In its place was substituted interesting diversions such as occupational pursuits and recreation. In America, however, authorities in the mental field carried on a long and acrimonious debate on the subject of restraint versus nonrestraint. The advocates of nonrestraint pointed to the success of this method of care in England. Their opponents emphasized the point that freedom-loving Americans, sane or insane, could not be coerced except by mechanical means. The long-drawn-out character of this debate is evinced by the fact that during the first fifty years of its existence the Association of Medical Superintendents discussed this subject at nearly every one of its meetings. Eventually, there came the dawning recognition that mechanical restraint stimulated and encouraged the very conditions it was supposted to eliminate. Some of the very superintendents who were loudest in their opposition to the principle of nonrestraint were at the same time busy reducing the use of mechanical coercion in their own institutions to a minimum.

While nonrestraint is a method of care of the patient and may broadly be viewed as a means of treatment, treatment of mental illness, in a medical sense, was almost nonexistent

in the latter part of the nineteenth century. The plain fact of the matter is that medical science, up to this time, had made little contribution to knowledge about mental disease. The state of knowledge of mental disorders was chaotic at this time. Order was brought out of this chaos by Kraepelin, who devised a new classification of mental diseases which laid the groundwork for a scientific approach to the problem. This classification was first introduced into America in a modified form in 1896 by Adolph Meyer, and the system still serves as the basis for classification of mental disorders in most American hospitals today.

Development of Psychiatry

More than mere classification was needed, however, before methods of treatment could be devised. A complete theory of the cause of mental disorder was lacking. It was not until Sigmund Freud published his work entitled "Studies in Hysteria" in 1895 that we get the beginnings of such a theory. Freud had become interested in the phenomenon of hypnotism and had been able to observe that when under the influence of hypnosis patients were able to recall ideas and incidents which in their normal waking state were beyond their ability to recall. Theorizing on this, Freud concluded that mental maladjustments and their expression in faulty behavior or faulty thinking can be the expression of mental conflicts existing at a deeper, or unconscious, level of the mind. He was able to show that when, through hypnosis, these conflicts were brought into the open, or to the conscious awareness of the individual, frequently remarkable cures resulted. Finally, Freud arrived at the conclusion that the personality of the individual is largely derived from the interaction of two opposing forces: inherited, instinctive drives or tendencies which are not at all social in their aim and which largely have the goal of seeking pleasurable satisfactions for the individual and the constantly molding influence of the environment operating on the individual and his drives from the moment of birth onward.

From all of this came a full-blown theory, not merely of mental illness, but of all forms of mental and personality

disorders ranging from the most serious forms to the minor maladjustments of personality. In substance, this theory states that the cause of such disorders lies in emotional conflict at the unconscious level, which conflict may have been generated by experiences reaching back to childhood or infancy, and that the cure for such disorders lies in the discovery and resolution of this conflict. As applied in treatment of functional mental disorders, that is, those which have no known organic cause, the searching out of such conflicts and the resolving of them is known as psychotherapy.

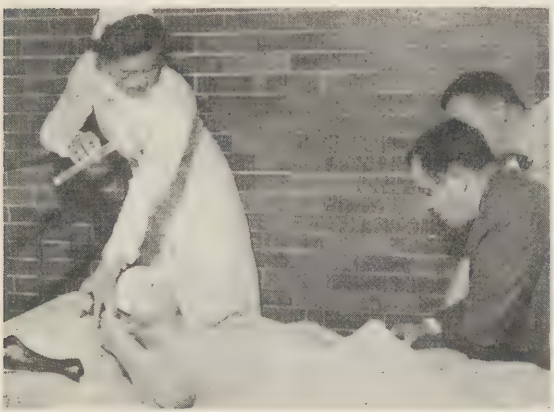
Another theory of mental disorder, American in origin, is that set forth by Adolph Meyer, and known as psychobiology. Somewhat less explicit and more difficult to explain than that of Freud, it has this in common with psychoanalysis, that personality is the product of constitutional or inherent biological factors of makeup as modified by the effects of past experience. This total experience must be reviewed to discover the particular experiences which produced the present maladjustments.

Likewise, some advance has been made in other forms of treatment. In 1913, Noguchi and Moore discovered the presence of the syphilis germ in the brain of persons suffering from the form of mental illness known as paresis, or general paralysis. Thus, the organic cause of this particular psychosis was definitely ascertained. In 1917, a promising remedy was supplied by the discovery of Wagner-Jauregg that in paretic cases a remarkable recovery was noted following an attack of erysipelas. This disease produced a high fever, and it was soon ascertained that it was the fever which effected the cure. Today, fever therapy, for the most part induced by the use of malaria, is in common use in the treatment of paresis, with very good results.

Two forms of "shock" therapy have been introduced in recent years in the treatment of dementia praecox cases with surprising results. How permanent the recoveries in these cases will be it is still too early to determine. In 1933, Sakel accidentally discovered that the shock induced by large doses of insulin resulted in the social recovery of a high percentage of dementia praecox cases. He stated his results from this

treatment cautiously when he said ". . . the net result (of his experiments in insulin shock treatment) is a percentage of remissions which is at least four times greater than the most optimistic figures for spontaneous remissions."

Miller and Medune experimented with another form of shock therapy, induced by a camphor derivative, which has come to be known as metrazol treatment. Results comparable with those obtained from insulin treatment were obtained. Today, both insulin and metrazol are being used in the treatment of other forms of functional psychoses. While good results are reported, it is still too early to attempt to evaluate them.



Both insulin and metrazol shock therapies have been in use at Richmond State Hospital for over a year. Central State Hospital is a pioneer in the use of fever treatment.

Importance of Early Diagnosis and Treatment

All of this marks progress which has been made in the treatment of the mentally ill. At last, definite steps are being taken actually to treat these patients. However, one great handicap remains to be overcome if significant results are to be achieved from these efforts. This obstacle is the attitude of the public toward mental illness and the mentally ill. Such illness is still regarded as a disgrace, something which should be concealed as long as possible; the mentally sick person is one who should be feared or, at least, regarded with suspicion. The result of this is that frequently mental illness is not brought to treatment until it has reached an advanced or acute stage. Too much emphasis cannot be laid

upon the necessity for early diagnosis and treatment to assure best results. The time has come when the public must be made to realize that mental disorders are forms of disease, differing only in their manifestations from physical disease. Another result of the public attitude of suspicion is that it makes the lot of the recovered or improved patient increasingly difficult when such a patient returns to society. He is denied employment; his friends behave strangely toward him; acquaintances shun his companionship. In a patient already unduly sensitive this makes complete recovery difficult and even sometimes impossible, for we are all social beings who, denied social contacts, develop new conflicts and the psychosis may recur.

Indiana Hospitals for the Mentally Ill

There is no reason to believe that the problem of mental illness is any more or any less serious in Indiana than in the country as a whole. On June 30, 1940, there were 8,433 patients in the five mental hospitals in this state. Details of those institutions and their operation are given in another section of this report. If the ratio of persons suffering from mental disease to the whole population computed for the entire country holds for Indiana, between 15,000 and 25,000 persons in this state are at present suffering from such illness. No actual count, however, has ever been made, so such figures are merely estimates based on the incidence of the disease in parts of the country in which more or less complete studies have been made. Whatever the actual number of cases in this state may be, this much is certain: only a fraction of the total number of cases is admitted to our mental hospitals. Until recently, many were excluded because of the overcrowded condition of those institutions. It will be only a matter of time until the increased facilities recently provided under the 1939-40 building program will be occupied to capacity. Sooner or later, the state will be faced with the necessity of making provision for some of those cases outside the mental hospitals.

Commitment Procedures

Admission to a state mental hospital in Indiana is obtained through commitment by a court. The court takes this action on the certification of two or more physicians that the patient is insane. After commitment, the patient is transported to the institution by the sheriff or other police authority. This system is, of course, a relic of the days in which the insane were housed in jails. This procedure is rationalized by claiming that the legal rights of the patient must be protected, but it does seem as if these legal rights could be safeguarded without the abuses which such a system fosters. In spite of all efforts to emphasize that mental illness is a disease and should be treated as such, the moment the state steps in to assist a mental patient it does so through the machinery of the courts, which are associated in the minds of most persons with the prosecution of criminals. Then, as if to complete the identification of the criminal and the insane, we admit these patients to the hospitals by court **commitment**, we may detain them in **jail** during trial if they are violent and we transport them to the hospitals in police cars in the **custody** of the sheriff. It may be that some of this procedure is necessary to safeguard the public and to assure that no person is detained in a mental hospital because someone wants him out of the way. As far as the latter point is concerned, however, the persons most capable of judging the mental condition of the patient are the members of the medical staffs of our state hospitals, yet the present system does not make adequate use of this resource.

To remedy some of the defects in the commitment procedure, the Division of Medical Care advocates revision of the commitment statutes to provide admission to Indiana's mental hospitals for a 30-day period of observation, this temporary commitment order requiring simply the signature of the judge when a petition for such an order is presented to him signed by two physicians.

It is also felt that transportation to the hospital should be the responsibility of the hospital and not of the sheriff, and that trained attendants should have the care of mental patients while en route to the hospital.

The Mentally Defective

Definition

Authorities differ in their use of the term, "mental defective". In general, there are a broad use of the term and a narrower use. The Subcommittee on Problems of Mental Deficiency of the White House Conference on Child Health and Protection adopted the broader definition of the term and included under it all persons who are intellectually subnormal, that is, all physically mature persons who have the mentality equivalent to that of a child of 12 years of age or less, regardless of the degree of social adjustment which such persons have attained. The narrower definition limits the use of the term to persons who, besides being subnormal intellectually, are socially inadequate. This last definition makes mental deficiency synonymous with feeble-mindedness, which, like insanity, is a legal term denoting the inability of a person to care for himself through lack of intelligence and who requires some measure of supervision and guidance, if not actual custody. This last definition, therefore, excludes the group of persons who are only slightly handicapped mentally.

Throughout the following discussion, this narrower meaning of mental deficiency will be used. The use of the term has been arbitrarily decided upon for practical reasons. The broader use of the term would involve discussion of educational methods and the public school system that would carry the problem far beyond the scope of the Department of Public Welfare. At the same time, it is well to bear in mind that this criterion of social inadequacy which separates the mildly mentally handicapped from those seriously handicapped is dependent upon the social environment, which is not always constant. In a changed environment, the mildly handicapped may become seriously handicapped. Consequently, when the time comes to talk of preventive measures in a mental health program, the definition of the mentally defective will have to be enlarged to include the mildly mentally handicapped cases.

Extent of Mental Deficiency

Estimates of the number of mental defectives in the general population vary greatly, ranging from 0.4 per cent to 15 per cent of the population. Part of the difference between these estimates lies in whether the psychological or the socio-economic criterion for determining mental deficiency was used. There is good reason to believe that somewhere near 15 per cent of the general population has a mental age of 12 years or lower, or, in the case of children, an intelligence quotient of less than 75. The portion of the population which is feeble-minded, in the sense that they are socially incompetent as well as of low intelligence, is probably close to two per cent.

On the basis of this two per cent estimate, Indiana has somewhere between 60,000 and 65,000 severely handicapped mental defectives in its population. The population of the institutions for mental defectives in this state at the end of the fiscal year was 2,851.

Even more startling than these figures is the estimate made of the proportion of low-grade types of mental defectives in the population. Following the psychological criteria set forth by the American Association on Mental Deficiency in 1934, persons having a mental age of less than three years and children with an intelligence quotient of less than 20 are grouped as idiots. Persons having a mental age of three years and under eight, or an intelligence quotient of from 20 to 49 inclusive, are classified as imbeciles. A moron is a mentally defective person usually having a mental age of eight years or upwards, or, if a child, an intelligence quotient of 50 or more. According to this Association, the upper limit for a diagnosis of mental deficiency, as a rule, should be an intelligence quotient of 69, but this limit should not be adhered to in cases where medical, social and other factors clearly indicate that the patient is mentally deficient. Although this definition of mental deficiency is based on mental tests, it should be remembered that, while such tests are useful and important, they are not an infallible index of mental ability in all cases. The Subcommittee on Problems of Mental Deficiency already referred to estimates that approximately half of the feeble-minded are of the idiot or imbecile type. In terms of the population of this state, such a figure means that

there are between 30,000 and 32,600 idiots and imbeciles among the population of Indiana.

Too much emphasis cannot be laid on the fact that these figures are estimates, based on figures for the country as a whole, which were derived from sample studies and data covering psychological examinations of the draft army during the World War. Application of these figures to Indiana can be justified, however, by the close correspondence to the figures arrived at by the Indiana Committee on Mental Defectives in its 1922 report. This committee reported, after studying 11 representative counties, three courts and various institutions, that at a conservative estimate 1.74 per cent of the general population of Indiana was feeble-minded.

Development of Institutional Care

The early history of the treatment of mental defectives closely parallels that of the insane. As early as the fourteenth century the term "idiot", or natural fool, was in existence and covered all classes of feeble-minded then recognized. Such "idiots" have traditionally been regarded as objects of ridicule or disgust. Perhaps they have not suffered quite as much as the insane, for, while they were regarded at some periods as persons possessed with a demon, they do not seem to have been subjected to much religious persecution. When they were regarded as dangerous to society, they were thrown into prisons; otherwise, they were simply neglected and forgotten. Because of their handicap, many of them were unable to earn a livelihood and, consequently, gravitated to almshouses and workhouses.

The first separate state institution for the training of mental defectives in the United States was established in Massachusetts in 1848, with Dr. Samuel G. Howe as director. In 1851, a similar institution was opened at Albany with Dr. Hervey B. Wilbur as director. The success of these two institutions did much to stimulate the building of separate institutions for the mentally defective. By 1866, there were seven such state institutions in as many states.

In 1879, Indiana gave recognition to this new movement by establishing the institution which later came to be known as the Fort Wayne State School as an adjunct of the Soldiers' and Sailors' Orphans' Home at Knightstown. In 1887, the legis-

lature gave the institution a separate existence, and a separate institution was built and occupied in Fort Wayne in 1890.

The history of the study of mental deficiency is marked by two developments of major importance. The first of these is the publication by Richard L. Dugdale in 1877 of his study of family degeneracy under the title, "The Jukes". The second is the development of mental testing and the mass application of such tests to the draft army during the first World War. The significance of both of these developments lies in the controversies which they precipitated.

Dugdale's work was followed by at least half a dozen other important studies along similar lines, all of which purported to show that mental deficiency was, for the most part, hereditary. What was more, they expressed the view that such deficiency was the major, if not the sole, cause of all social ills. The hopelessness of this point of view was depressing. It served to retard the development of institutions for the training of mental defectives, and many of them became mere custodial institutions. If the problem was one of heredity, and as serious as these writers had indicated, the only thing to do was to seek ways and means of preventing reproduction among the feeble-minded. From this thought sprang later attempts to control the problem by means of sterilization of defectives.

Mental Testing

A much more constructive approach to the problem was made when means were devised to measure intelligence, although application of this discovery caused great consternation when the results of the draft army tests revealed a greater proportion of persons in the general population with subnormal intelligence than had ever been anticipated.

An excellent opportunity presented itself for testing a generous sample of the population of the United States at the time of the first World War. This opportunity was seized upon and intelligence tests were administered to virtually the entire draft army. Results of these tests were published with little interpretation. Alarmists hastily concluded that almost half of the population was mentally defective. This mass testing program, however, was experimental and was carried on at an early stage in the development of a new field. The experiment revealed defects in the testing methods which

would not have been uncovered for years without this vast experience. Since then, mental testing has been subjected to many refinements, and the limitations of these tests have become better known. The total result is that today mental testing is now a relatively accurate method of determining the degree of intelligence. It should be emphasized again, however, that mental testing must not be regarded as the sole criterion of feeble-mindedness. Such testing must constantly be subjected to close scrutiny and related to the degree of social adjustment achieved by the person tested. Mental testing is a guide, not a final and irrevocable pronouncement on the mental capacity of an individual.

Causes of Mental Deficiency

Causation of mental deficiency is a highly controversial subject. There are, however, two general classes of causes which are commonly accepted. One class may be termed primary, indicating that the causes are largely hereditary in origin. The other class may be called secondary, indicating that the causes in this group operate before, during or soon after birth. As knowledge in the field increases, more types of deficiency are being removed from the primary group and placed under the secondary.

From an early date, mental deficiency has been attributed to familial transference through the medium of the germ plasm. Theories of heredity are undergoing modification, and less emphasis is being placed upon the importance of heredity as a factor in the production of feeble-mindedness. At one stage in his career, Dr. Walter E. Fernald laid complete emphasis upon the heredity aspect of such deficiency. Before his death in 1924, after 38 years of experience, he concluded, as the result of his studies, that fully half of all cases of mental deficiency were of the secondary, or nonhereditary, type.

The secondary type of mental deficiency can be attributed to certain physical causes. Dr. Abraham Myerson lists the following causes of such mental deficiency:

1. **Trauma at birth or severe head injuries during early childhood.**
2. **Infectious diseases during childhood affecting the nervous system, such as encephalitis, meningitis, etc.**
3. **Malfunctioning of the endocrine glands.**
4. **Toxic conditions.**
5. **Syphilis.**
6. **Malnutrition.**

No figures are available to indicate the relative importance of any of these causes. Research along these lines will throw light on this problem in the future.

There is considerable debate carried on at the present time as to the influence of environment on mental capacity. Until quite recently it was generally accepted that once the mental level of a person was established, barring the onset of diseases which might produce mental deterioration, the mental ability of that person would never change, regardless of any amount of education or training or any other social circumstance. If mental tests given at different times showed variations in their results, the explanation was to be found in the test situation. This hypothesis of the unchangeability of the mental level has been questioned in recent years by a number of persons. Studies have been undertaken which showed that children coming from an unfavorable home environment tested at a higher level when they were placed in a more favorable home situation. Conversely, the I.Q. of children placed in less favorable environments decreased. The conclusion drawn from these studies has been that cultural factors influence the I.Q., particularly such factors found in the home situation. At every turn when this evidence has been presented, some psychologists have disputed the conclusions. While the evidence at present is too fragmentary to draw definite conclusions, there does seem to be some support for the contention that there may also be social causes of mental deficiency.

Indiana Institutions for the Feeble-Minded

At the present time, Indiana maintains two institutions for the feeble-minded, the Fort Wayne State School, at Fort Wayne, and Muscatatuck Colony, near Butlerville. Originally, Muscatatuck Colony was a custodial institution for adult males. Over the past two years an extensive building program has been carried on at this institution and the character of the Colony has been changed to that of a school for the training of mental defectives who come from the southern half of the state. From the beginning, Fort Wayne State School has been operated as a training school for mental defectives. At present, the Fort Wayne school serves the northern half of the state. Chart III is a map which shows the counties served by each of these two institutions. Further discussion of these schools for the feeble-minded will be found in another section of this report.

CHART III

LOCATION OF STATE INSTITUTIONS FOR FEEBLEMINDED AND DISTRICTS SERVED BY EACH

APRIL 1, 1940

It hardly need be emphasized that the results obtained from training the feeble-minded depend primarily upon the degree of mental deficiency in each case. Often admitted are patients of extremely low mentality who cannot clothe or feed themselves or otherwise perform simple services for themselves. In such cases, maximum training is probably reached when they are taught to care for their own simple needs. On the other hand, high-grade morons can be taught difficult man-

Inmates of Muscatatuck Colony are schooled in academic and vocational subjects.

ual skills. Training, therefore, is preceded by determination of the probable degree of trainability of the patient. Academic education is not neglected in teaching the feeble-minded in this state, but it should be remembered that only a portion of the population of these institutions can profit by such training. It is recognized that an illiterate person is severely handicapped in present-day society, so that patients are taught to read and write whenever it is possible to do so.

Community Responsibility

The problem of mental deficiency is really a community problem. The state never can build enough institutions to house all of the mental defectives in the state, nor would such

a program be advisable even it were feasible. Many persons who are below the average in mental ability make a successful social adjustment. The responsibility of the community to such handicapped persons is to make sure that they have opportunity to develop such resources as they possess. Obviously, early discovery of mental incapacity is essential if adequate training is to be provided. The logical place for such a program to be carried out would be in the public school system. Some method of mental measurement of all children should be developed, preferably in the early grades of school. Cleveland, Ohio, for example, tests all its school children mentally. Instead of labelling each with an intelligence quotient, school authorities there speak of the "probable learning curve" of the child. All subsequent training is geared to the ability of the child to learn. Not only would this serve as a means of training many of the mentally subnormal children right in the community and at an age when such training should be undertaken, but it would prevent the development of grossly maladjusted personalities from which most behavior problems spring.

Commitment Procedures

Under the present system in this state, persons are admitted to the feeble-minded institutions on commitment by the court. The procedure is similar to that used for the commitment of psychotics. On certification by two or more physicians that the patient is feeble-minded the court orders commitment to such an institution. In cases in which the feeble-minded person has become a community problem, that person not infrequently is held in jail until commitment is obtained or until there is a vacancy in the institution to which he is committed. Considerable delay has been experienced in the past between commitment by the court and admission to the institution. This has been because of the greatly overcrowded condition of these institutions. Only this year has this condition been improved. Prior to this time, each institution had long waiting lists for admission. With the completion of the new buildings at Muscatatuck Colony, these waiting lists have been absorbed. But present indications are that both institutions will shortly be filled again to capacity, and now waiting lists will have to be started.

The Epileptic

Institutional Care

The epileptic is the last group to have been removed from the poor asylums and, latterly, from mental hospitals and institutions for the feeble-minded. Only within the last half century has a serious attempt been made to place epileptic patients in a separate institution designed especially for their care. In general, the colony type of institution is the type that has been developed in this country for the care of such patients. The first separate institution for epileptics built in the United States was "The Asylum for Epileptics and the Epileptic Insane" opened at Gallipolis, Ohio, in 1891. The growth of separate institutions for the care of this type of patients has been slower than that for the care of the psychotic or the feeble-minded. By 1933 there were only 11 such state institutions in this country, one of them being the Indiana Village for Epileptics at New Castle, which was opened in 1907.

Commitment Procedures

As in the case of the mentally ill and the feeble-minded, the method of admission to the Indiana Village for Epileptics

This is one of the new buildings at the Indiana Village for Epileptics, where scientific treatment, education, employment and custody are provided for persons afflicted with epilepsy.

is by court commitment upon the certification of two or more physicians. For some years the institution has suffered from overcrowding. On June 30, 1940, it had a population of 931 patients, while its normal capacity is 915 patients. At the end of the last fiscal year, there was a waiting list of 136 patients.

Nature of Epilepsy

Epilepsy is a disease which is characterized by attacks of loss of consciousness which may or may not be accompanied by convulsions. The irregular occurrence of these attacks and the brief warning, or entire absence of warning, of the onset of an attack seriously handicaps the sufferer in employment in particular and in social activities in general.

As in the case of mental disease, there has not been established any one cause which is responsible for all epilepsy, nor is there agreement among authorities as to the causes of epilepsy. The American Psychiatric Association classifies epileptics into two groups, symptomatic cases and idiopathic cases. Symptomatic epilepsy means that the epileptic seizures are symptoms of a definite disease. Idiopathic epilepsy covers that group of cases in which the underlying cause is unknown or where the epilepsy can not be shown to be associated with or caused by any known disease. The cause of idiopathic epilepsy is believed by some to be the instability of the chemical structure of the nerve cells of the brain. However, others are inclined to the view that in the functional type of epilepsy there is evidence of emotional pathology. There seem to be some definite emotional patterns related to the convulsive states. In the more obvious cases this is termed histero-epilepsy. In the less obvious cases the emotional disturbance may be quite deep-seated. Thus it is possible that some cases of idiopathic epilepsy, in reality, may be emotional disorders.

Figures are not available at the present time to show the relative importance of these two types of epilepsy. Various governmental and medical agencies have urged the need for research along this line and it is expected such figures will be available for Indiana next year.

It is extremely difficult to obtain reasonably accurate figures on the extent of epilepsy. Figures for epileptics in institutions merely reflect the capacity of the institutions and tell nothing of the incidence of the disease. The only available index of the incidence of epilepsy was established when over 2,000,000 men were examined for the draft army during the World War. As a result of those examinations, it was found that 515 in each 100,000 of the drafted men were epileptic. Because these men were between 18 and 30 years of age and because the rate of epilepsy is high among children and relatively few epileptics live to an advanced age, this figure is not representative. The Subcommittee on Problems of Mental Deficiency of the White House Conference previously referred to estimated for persons under 20 years of age a rate of 800 or 900 epileptics to each 100,000 of the total population. On the basis of Indiana's population as given in the 1940 census, this means approximately 10,000 persons in this state under 20 years of age suffer from epilepsy. By adjusting for the prevalence of this disease at various age levels, a figure of 16,000 epileptics can be arrived at for the total population of Indiana. This estimate seems high in comparison with the findings of the study of the Indiana Committee on Mental Defectives covering the years 1916 to 1922. This committee made what was termed a conservative estimate of 0.15 per cent of epileptics in the population as the result of a study of 11 counties and several institutions. This percentage would show a total of approximately 3,000 epileptics in the state on the basis of the 1940 census figures. Assuming that the one estimate is high and the other low, the probability is there are somewhere in the vicinity of 10,000 epileptics in this state.

Medical Control of Epilepsy

In recent years, considerable research has been conducted in search for a drug with which to control epileptic seizures. Some measure of success has been achieved by the use of phenobarbital. More recently, some excellent results have been reported from the use of dilantin for this purpose. Although it is still too early to evaluate the results of this latter treatment, it does look promising, and at least a beginning has been made in the medical control of such seizures.

DUTIES OF THE DIVISION OF MEDICAL CARE

The functions of the Division of Medical Care were set forth in Section 9 (c) of the Welfare Act of 1936 in the following words:

> "The division of medical care shall have immediate charge of the supervision of the several public benevolent institutions of the state and of all non-institutional care connected therewith, the operation of the Central, Logansport, Richmond, Evansville and Madison state hospitals, the Fort Wayne state school, the Muscatatuck colony, the village for epileptics, the soldiers' home and the state sanatorium, all agencies and institutions of the state caring for dependent or mentally or physically handicapped or aged adults and the approval of the incorporation of charitable agencies."

Supervision of Institutional Care

In attempting to carry out the terms of the Welfare Act, which allocates to this Division the responsibility for the supervision of certain state institutions and the noninstitutional care connected therewith, the Division has stressed the introduction of the most progressive type of care and treatment known to medical science and has sought to initiate a state-wide program of prevention.

In connection with the development of this program, certain features of the relationship between the Division of Medical Care and the institutions need explanation. By way of clarifying the use of the term "supervision" in the Welfare Act, the Attorney General gave an opinion in which he interpreted this term as conferring upon the Department of Public Welfare, through its various divisions, something more than the power to inspect and recommend, yet implied that it was something less than complete control over the institutions. Subsequently, the institutions were transferred by executive order from the state welfare department to the Executive Department, under the supervisor of state institutions. Thus, the Division of Supervision of State Institutions obtained direct supervisory authority over the institutions.

In this situation, the Division of Medical Care co-operated closely with the Division of State Institutions and, through the establishment of co-operative relationships with the superintendents, worked with them towards improving institutional

standards. Since the relationship between the Division of Medical Care and the institutions depends, at present, very much upon the willingness of the individual superintendent to co-operate, situations arise from time to time which might be met more adequately if the Division of Medical Care possessed more definite authority.

Central guidance of institution programs, through qualified medical and professional personnel, is a pattern rapidly being adopted in other states. In the past, where such plans have been put into operation, there has always resulted more efficient, more advanced and more economically sound mental health programs. At present, the Division of Medical Care possesses the organization and qualified personnel to assume more direct responsibility in administering the institution program. This could be brought about by placing the institutions under the Department of Public Welfare and by some change in the Welfare Act more adequately defining the responsibility of this Division.

Treatment Versus Custody

One of the first steps taken by the Division of Medical Care was to carry on a campaign for the reduction, if not entire elimination, of restraint and seclusion in the mental institutions. It is not enough to take the shackles off the disturbed mental patient. Something must be done to relieve that disturbed condition. The use of hydrotherapy for this purpose has been found to give excellent results. Its use in this state has been greatly increased in the past few years. The chief bar to its greater use lies in the fact that these institutions are greatly understaffed. It requires more personnel to give adequate medical care to these patients than it does to give them custodial care. The mental institutions in this state are struggling to become treatment centers at approximately the same per capita budget level as they operated on in the days when little or no treatment was attempted. Much credit is due them that they have been able to effect as many improvements as they have in view of this obstacle. The time has come, however, when further improvements hinge upon whether or not they are provided with additional funds to increase their personnel. Considerable improvement has already been effected in decreasing the use of restraint and seclusion, but there is still much to be achieved along this line.

The patient is taking a Rorschach test, results of which will help the psychiatrist to understand the mental sufferer's imaginative processes.

Fever Therapy

As already indicated, certain methods of treatment have been found to give promising results. Use of these methods has been encouraged in Indiana's institutions. One method of treatment, the use of fever therapy for paretic patients, has long been in use in this state. Research in this field carried on over many years under the direction of Dr. Max A. Bahr at Central State Hospital has won nation-wide acclaim.

Shock Therapy

Use of the shock therapies, insulin and metrazol, has been increased and some excellent results have been obtained. Many extravagant claims have been made for these methods of treatment, but one would do well to scrutinize carefully all figures quoted on the subject. Both insulin and metrazol have been in use at Richmond State Hospital for over a year. A total of 67 patients was treated by the insulin method and 114 patients by the metrazol method, with improvement noted in approximately 40 per cent of the cases.

It has now been definitely established that best results are obtained when treatment is given in the early stage of the

disease, particularly in cases where the illness has been of less than six months' duration. It should be pointed out that the great majority of the cases treated at Richmond were cases whose illness was of two to five years' duration. In those cases where the illness was of less than six months' duration, as much as 58 percent recoveries were reported.

The Problem of Adequate Personnel

The problem of proper care of patients in the mental hospitals of this state is largely a matter of the ability or inability of these institutions to employ adequate personnel, adequate both in training and in numbers. Most persons employed as attendants at these hospitals have not had previous experience in this line of work. To overcome this handicap, the Division has instituted a training course given by its supervisor of nursing to all attendants. However, it is felt that the amount of training it is possible to give in this way is inadequate. An effort is being made to have this work done by graduate nurses in each institution. The Division has also prepared and distributed an Attendants' Manual, which is a handbook of instruction on the care of mental patients. Gradually the limited amount of instruction is helping to improve the standards of care. There is a great need, however, to have well-trained personnel in the institutions to supplement these instructions. It is felt that there should be a sufficient number of graduate nurses in each institution so that each would have a director of nursing, who would be directly responsible for all nurses and attendants, and graduate nurses in all key positions on both male and female services.

The need for improvement in the quality of personnel cannot be emphasized too strongly. All along the line, from the superintendent and staff physicians to the attendants, each should be fitted for his job by training and experience. Only by employing capable personnel can full advantage be taken of the new buildings recently acquired. Without such personnel, the program in the institutions must be severely limited, for modern methods of care and treatment demand greater skill and knowledge than is necessary for custodial care. If the programs in these institutions are to be progressive and abreast of the times, the men and women who operate these programs must themselves be abreast of the

This patient doesn't like the idea of even a painless intravenous injection.

Basket - weaving, rug-making and embroidery work are some of the forms of occupational therapy used to provide employment for the hands of the mentally ill. Many products are of great beauty.

Indiana's hospital plants and equipment are unrivaled by those of any other state.

times. Buildings themselves do not cure or heal, nor is there any mechanical way by which recovered patients can be turned out. The human element is still vitally important.

As to numbers of personnel, a comparison may serve to make this situation clear. The American Psychiatric Association has set up a series of standards showing the numbers of various types of personnel required in mental hospitals to provide adequate care for the patients. Standards are given in terms of a ratio of the number of personnel to patients. For physicians (exclusive of the superintendent), this is given as one physician for every 150 patients; for nurses, one nurse to every 60 patients; for attendants and nurses combined, one attendant or nurse to every eight patients. While some few states have attained these standards, they are somewhat idealistic. Their use, however, will serve to show how far Indiana's mental hospitals fall short of the ideal. Table 1 shows the average number of physicians, nurses and attendants employed by these institutions during the fiscal year ending June 30, 1940, as contrasted with the number called for under the American Psychiatric Association standards.

TABLE 1

PERSONNEL EMPLOYED IN INDIANA STATE HOSPITALS DURING YEAR ENDING JUNE 30, 1940, COMPARED TO REQUIREMENTS UNDER AMERICAN PSYCHIATRIC ASSOCIATION STANDARDS

Institution	Physicians		Nurses		Nurses and Attendants	
	Employed	APA Standards (1 in 150)	Employed	APA Standards (1 in 60)	Employed	APA Standards (1 in 8)
Central	4	13	0	34	154	254
Logansport	5	12	4	31	145	237
Richmond	4	11	5	27	151	203
Evansville	5	8	3	20	85	148
Madison	5	10	1	26	126	197

It should be mentioned that some of the hospitals have increased the number of graduate nurses employed since the beginning of the 1940-41 fiscal year. From these figures, it will be seen that the greatest inadequacy in Indiana's mental institutions today is the lack of sufficient personnel. Thanks to the recent building program, the hospitals have adequate facilities in this respect, but buildings themselves do not effect cures. There is great likelihood that the advantages gained in the improvement in plant and equipment will be lost through the inadequacy of the staffs which will make use of these.

Some thought must be given to the hours of duty required of nurses and attendants. The 11-hour day, seven-day week is still in operation in this state. Some time off is allowed, of course, but attendants work approximately 70 hours a week. The trying character of the work of these state employees, complicated by long hours, imposes a strain on them which is not conducive to the best type of care of the patients.

The problem of adequate personnel is at bottom a financial problem. Institutions can operate only within the limits of their budgets. Chart IV shows the per capita cost of operating the mental institutions in this state over the last fifteen years. In general, the trend in expenditures for operation has been downward, which is explainable, in part, by the drop in the cost of living during the depression years. In this same period, methods of care and treatment have changed, calling for a switch from custodial care to medical treatment, a program which is avowedly more costly. This is reflected in a comparison of per capita operating costs of Indiana's mental hospitals with those of other states where this progressive program has been put into full force. Table 2 shows this comparison. The whole issue of adequate care for the mentally ill can be reduced to the question of whether economy of operation or restoration of the patient to mental health and to his community is the paramount consideration. Yet there is another economic consideration which must be weighed. Unless it is possible to return mental patients to their communities at a faster rate, Indiana shortly will be faced with the necessity for spending more millions for the building of additional mental hospital accommodations.

CHART IV

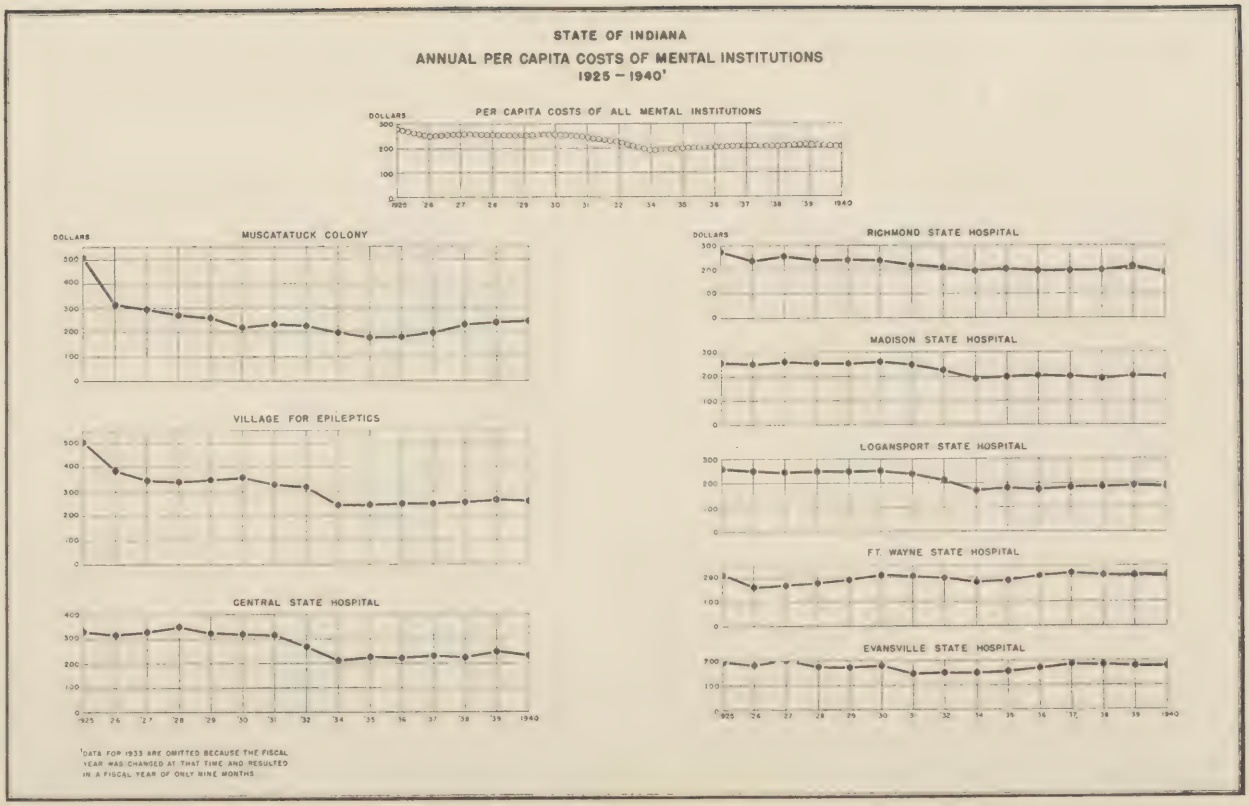

STATE OF INDIANA
ANNUAL PER CAPITA COSTS OF MENTAL INSTITUTIONS
1925 – 1940¹
PER CAPITA COSTS OF ALL MENTAL INSTITUTIONS
DOLLARS
MUSCATATUCK COLONY
VILLAGE FOR EPILEPTICS
CENTRAL STATE HOSPITAL
RICHMOND STATE HOSPITAL
MADISON STATE HOSPITAL
LOGANSPORT STATE HOSPITAL
FT. WAYNE STATE HOSPITAL
EVANSVILLE STATE HOSPITAL
1925 26 27 28 29 30 31 32 34 35 36 37 38 39 1940
¹DATA FOR 1933 ARE OMITTED BECAUSE THE FISCAL YEAR WAS CHANGED AT THAT TIME AND RESULTED IN A FISCAL YEAR OF ONLY NINE MONTHS.

TABLE 2

AVERAGE PER CAPITA COST OF OPERATING INDIANA'S MENTAL HOSPITALS COMPARED WITH THAT OF OTHER STATES

State	Average Annual Per Capita Cost
Indiana (1940)	$198.57
Illinois (1938)	265.63
New Jersey (1934)	388.00
New York (1939)	402.96
Massachusetts (1939)	420.37

Comparison of the number of patients admitted for the first time to a hospital in any one year with the number discharged from that hospital in the same period affords a fair index of the efficiency of its treatment program. In 1937, this ratio of first admissions to discharges in Indiana was exceeded by 36 states, placing Indiana in the 37th position in rank of states, or 12th from the bottom of the list.

After making allowances for the difference from state to state in the cost of mental hospital operation because of local conditions, it must then be considered significant that Indiana in 1937 ranked 34th in the list of states in its per capita costs in its hospitals. This comparison strongly suggests that hospitals enjoying a higher per capita allowance also tend to show a higher first admission-discharge ratio.

These figures indicate all too clearly that in 1937 Indiana's mental hospitals did not return to the community as large a proportion of their patients as would be expected by reference to the figures for all states. Since the institutions were filled virtually to capacity in 1937, this failure to discharge did not in that year result in an appreciable increase in the

hospital populations, but certainly it forced hospitals to deny admission to many who, had there been a more active treatment program, could have been admitted. If the 1937 first admission-discharge ratio for Indiana is maintained now that increased hospital accommodations have been provided, it is obvious that a large yearly population increase can be expected. This means that chronic patients again will accumulate in the hospitals and, even with the provision of new buildings, a saturation point in admissions will soon be reached again.

Social Service for Mental Institutions

Case Studies of Patients

In line with what has been said earlier on the theories concerning the causes of mental illness, considerable emphasis is being laid on the need for a social work program in the mental institutions of this state. Both psychoanalysis and psychobiology insist that to understand and ultimately to treat each individual case of psychosis it is essential to know as thoroughly as possible the social history of the patient. The task of collecting all this information is enormous. In the past, attempts were made to secure as much of this data as possible by the use of an elaborate commitment paper on which the court was supposed to record information on the patient and the patient's family in answer to specific questions. This placed a burden on the court which the court was not in every instance able to assume. The total result was that such social information supplied by the court was often inadequate and not infrequently incorrect.

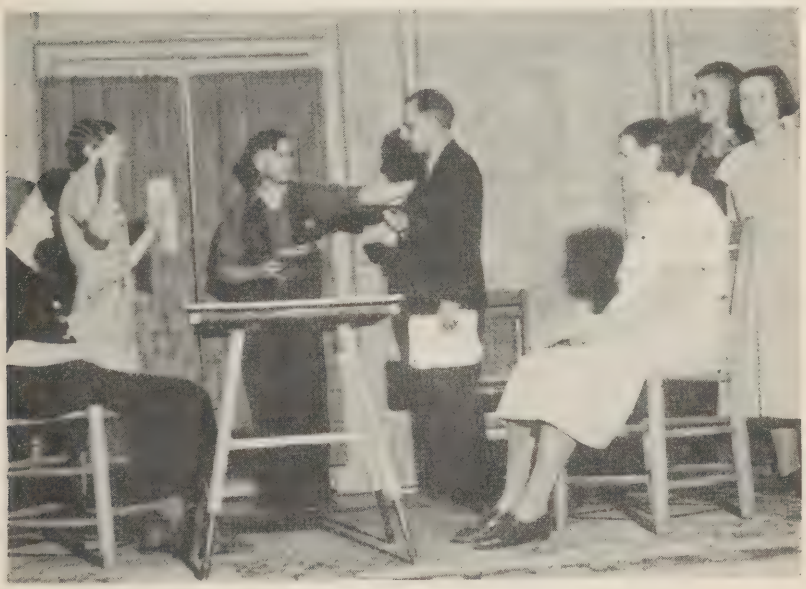
With the growth of social work as a profession in the past decade, and in particular those trained in the psychiatric field, there are now available persons with special techniques for obtaining and recording this information. Three of the five mental hospitals and both institutions for the feeble-minded now have a social worker on their staffs. Obviously, this handful of workers could not perform this task themselves. Plans have been worked out, therefore, to utilize the workers on the staffs of the county departments of public welfare to prepare histories for cases committed from their own county.

In this way, ultimately for every new patient committed, a complete social history will be available.

Returning the Recovered Patient to the Community

Return of the recovered or improved mental patient to his community is a problem which presents many difficulties. The precipitating cause of the individual patient's mental breakdown almost always lies in his social environment. In releasing a patient, the question inevitably comes up as to whether the situation which was responsible for the previous break still exists, and, if it does, how much such a situation will contribute to the retardation of his recovery or possible recurrence of the mental illness. On the positive side, there is the question of what community resources are available to stimulate the recovery of the patient. Naturally, the institutions are remote from all communities, excepting possibly the one in which the institution is located, so that information on the community and family environment into which a furloughed

Least disturbed patients and those nearing recovery work and play at pursuits approaching the normal life of any community. Below, a group is presenting an amateur play. Dances and movies are other forms of recreation. Work on the farms or in the upkeep of the institution also has its place.



patient returns is sadly lacking. In the interests of an efficient furlough system, some liaison between the new environment and the institution had to be developed. This function has been allocated to the institution social worker, whose task it is to learn all pertinent facts about the social situation into which a prospective furlough patient will go. In addition, this worker keeps in contact with the patient while on furlough and assists the patient in adjusting again to the outside world.

If the mental institutions in this state are to be protected against the overcrowding which existed prior to the development of the recent building program, some means must be found to effect a more rapid turnover of the patient population.

The Excess Per Capita Evil

However, there is a factor which makes for some resistance on the part of the institutions to a too active furlough program. There are two methods of appropriating funds for the operation of state institutions in use in this state. The one method is that of the approval by the legislature of a biennial budget for each institution. This is supplemented by another method, known as the "excess per capita allowance". Briefly stated, this is part of the state budget which authorizes the payment of an additional appropriation to specified state institutions calculated upon the excess in average daily population for any given month over a fixed base population. If the base population for any given institution is fixed at 1,000 patients, and the institution had an average daily population in July of 1,500, an additional appropriation would be made available to that institution of 500 times the annual amount fixed for payment per patient, usually $200, divided by 12 (since the amount is set up on an annual basis, but payments actually are computed on a monthly basis). In other words, this institution would be entitled to an additional appropriation of $8,333.33 because its population during July exceeded its base population by 500. It would be entitled to additional amounts for every other month in the year, depending upon how much its average daily population for the month exceeded its base population.

This method of determining the budget of institutions is open to some objections from the standpoint of the operation of the institutions. In the first place, the superintendent never

knows exactly how much money he will have available for the operation of his institution because of the chance factor, namely, the unpredictability of the size of his population. This makes it difficult to plan his program in advance. On the item of personal service, this results in unnecessary hardship. The budget of the institution is cut so closely that the superintendent does not know ahead of time whether he can employ three physicians or four, 100 attendants or 125, without gambling upon his excess per capita allowance. If he employs the larger number, his population may remain fairly constant and no difficulty result, but, should his population drop in any one month, part of his anticipated appropriation vanishes and he may have to discharge some of his employees. With a subsequent rise in population, the whole process has to be repeated.

In practice, what happens is that some measure of control may be exercised over the population. Some patients may be ready for furlough, but their release might reduce the institutional budget and thus jeopardize the rest of the institutional program. Development of an active furlough program is too much to expect, therefore, if that program is going to curtail the already limited institutional budgets necessary for maintenance of the institutions.

The excess per capita allowance method of appropriation is a vicious system tending toward the development of a static population at a high level, resulting in overcrowding in the institutions. It should be abolished, and a fixed appropriation, based upon the needs of the particular institution, substituted.

Sterilization

As already pointed out, there was a period in the history of the study of mental deficiency when it was believed that virtually all social ills were the product of feeble-mindedness. In the wave of resentment which followed the preaching of this doctrine, there was considerable agitation for the sterilization of all the feeble-minded for eugenical reasons. This resulted in the passage of sterilization laws in many states, Indiana being the first state to pass such a law. In subsequent revisions, this law was extended to cover the sterilization of psychotic patients as well as feeble-minded.

The situation as it stands in this state at present may be summed up in three points: (1) Sterilization for reasons of mental condition can be performed only on persons committed to one of the state institutions for the feeble-minded or to one of the state hospitals. There is no provision for sterilization, on those grounds, of persons in the general population. (2) The court may, at time of commitment, order a patient sterilized after admission to the institution. (3) Sterilization may be performed on patients not ordered sterilized by the court provided certain rules concerning the filing of a petition and holding certain hearings are observed. This petition must be approved by the State Board of Public Welfare before the operation legally can be performed.

In practice, social considerations weigh heavier in deciding whether or not to sterilize a patient than does the question of the transmission of an hereditary taint. Before feeble-minded patients are released on furlough, consideration is given to the question as to whether they are socially adequate and are likely to be able to support a family. The matter of probable sex delinquency is also considered. If there is likelihood that the patient will not make adequate adjustment on these two points, he is sterilized before being released on furlough, as are all those whose feeble-mindedness is definitely shown to be of familial character. Thus, selective sterilization of the feeble-minded is practiced in this state.

The situation is somewhat different with regard to the sterilization of psychotics. On the form on which the physicians report their findings to the court concerning the mental condition of a patient for whom a petition to commit to a mental hospital is being heard by the court is a question which, in substance, inquires if the patient is likely to have offspring who will be mentally impaired. To this question the physician must answer "yes" or "no". On the strength of an affirmative reply to this question, the court orders the sterilization of the patient within a given time after admission. If the order is not complied with within the stipulated time, it lapses and sterilization may not be performed. In practice, what happens is that many physicians answer this question routinely in the affirmative, and many judges routinely order sterilization. In the institutions there is variation in the practice. Some

superintendents sterilize all patients so ordered by the court routinely. Some permit all orders to lapse. Others make a selection for sterilization and permit the rest to lapse.

The difficulty in the situation is that in scientific circles the value of eugenical sterilization is being seriously questioned. Gradually, the importance of heredity is dwindling and greater emphasis is being laid on environment. The American Neurological Association appointed a committee to make an exhaustive study of the subject of eugenical sterilization, and the report of this committee is one of the best pieces of work in the field. This committee made four general recommendations, which may be summarized as follows:

1. Any sterilization law passed in the United States should be voluntary and regulatory rather than compulsory.
2. Such a law should be applicable not only to patients in state institutions, but also to those in private institutions and those at large in the community.
3. Sterilization should be determined by a board consisting of persons with training and experience in the problems involved.
4. Adequate legal protection should be approved by statute to the members of this board and to the surgeons carrying out its recommendations

On the matter of whom should be sterilized the committee recommended sterilization in selected cases of certain diseases and with the consent of the patient or those responsible for him. They recommended that such selective sterilization be considered in cases of the following diseases:

(1) Huntington's chorea, hereditary optic atrophy, familial cases of Friedreich's ataxia and certain other disabling degenerative diseases recognized to be hereditary.
(2) Feeble-mindedness of familial type.
(3) Dementia praecox (schizophrenia).
(4) Manic-depressive psychosis.
(5) Epilepsy.

Together with those recommendations, the committee submitted some carefully worded notes on each of these diseases. In the case of dementia praecox, they remark that this disease will need little attention from the surgeon because the disease

itself results in lowering of the sexual urge. Further, they warn that the recommendation of the use of sterilization does not apply to cases of schizoid personality. As for manic-depressive psychosis, the decision to sterilize such patients will tax the judgment of the wisest board, for the temperament found in these patients is frequently the source of the highest achievement and ability of which mankind can boast. With respect to feeble-mindedness and epilepsy, they point out that the major consideration is social rather than biological.

Sterilization, then, to be effective, should be selective, and the decision to sterilize or not to sterilize should not be a function of the court, but should be the considered judgment, after adequate study of each individual case, of persons qualified to pass upon such a matter.

Mental Hygiene

Medical science has created for itself an enviable record in the past quarter of a century. That record reveals itself in the reduction of the death rate, but such reduction tells only part of the story; it neglects that portion which tells of the avoidance of suffering from illnesses which are not always fatal. Part of this record is due to the discovery of remedies for specific diseases. The remainder is attributed to the emphasis upon and the development of a program of prevention of disease. So successful has this program been that in the thinking of the medical profession prevention of disease is as much a part of their service as cure.

This emphasis has been slow to develop, however, in the field of mental disease. In the very nature of the case, prevention was impossible until there was some knowledge of the causes of mental illness. From the beginning, the National Committee for Mental Hygiene envisaged a program of prevention, yet 12 years slipped by during which scant effort was made toward entering the field of prevention. It was not until the groundwork of an adequate theory of mental illness had been laid that light was shed upon the problem of where to begin with prevention. It had to be shown that apparently minor personality maladjustments were of the stuff of which psychoses were made before there could be organized effort to treat such maladjustments. In 1922, the National Committee

formally launched its campaign of prevention by opening, in conjunction with the Commonwealth Fund, its five-year program of mental hygiene clinics. This marks the beginning of organized effort at prevention in the mental health field.

Establishment of Mental Hygiene Clinics

Early in 1939 the Division of Medical Care of the state welfare department opened its first mental hygiene clinic at Columbus. From that time, the number of the clinics in operation has increased to 14. These are located at strategic points throughout the state, so that mental hygiene clinic service is available to virtually every county.

Operation of Mental Hygiene Clinics

Each clinic team consists of a psychatrist, who is director of the clinic, a psychologist and a psychiatric social worker. The social worker also serves as secretary to the clinic and acts as liaison officer between the local community and the clinic. The clinics operate from Indianapolis, making a one- or two-day visit every other week, the number of clinic days' service given to each area being determined by the needs of the area. The Marion County clinic is an exception in that a full-time clinic is maintained here because of the population of the area served.

Because a clear understanding of the problems facing individuals who come to these clinics cannot be secured without a fairly complete knowledge of their historical background, a complete social history for every patient is insisted upon. Collection of this material and presentation of it in usable form requires a considerable amount of work. Obviously, this work could not be undertaken by the small staff operating from the central office. The co-operation of the county departments of public welfare and other local agencies in the preparation of these histories actually makes possible the extensive mental hygiene program in this state. The clinics utilize those services which are already established in each community. Local physicians make the physical examinations; the clinics co-operate with the local medical societies; advisory committees are established in many clinic areas. In this way,

Children who have difficulty in adjusting to the rules of modern life may now be brought to mental hygiene research clinics for expert diagnosis and treatment. Modern psychological tests frequently discover the causes of truancy, undue timidity or other undesirable social traits.

many times the number of persons employed in the state clinic units are actually working throughout the state on mental hygiene problems. In other words, the clinic personnel has been increased by utilizing trained and lay workers in each community.

Each patient attending such a clinic is examined by the psychiatrist after the report of the medical examination of the patient by a local physician has been studied. This psychiatric examination brings to light the emotional conflicts and maladjustments which underlie the patient's behavior. Whenever it is deemed necessary, the psychologist gives the patient a series of intelligence tests designed to reveal the mental equipment of the patient and to uncover any intellectual traits or abnormalities which might have a bearing upon his problems. At the close of each clinic day, a staff conference is held to discuss the findings of the various members of the clinic staff in relation to the social history. As the result of this conference, recommendations are formulated, citing methods and suggesting changes which will enable the patient to overcome his difficulties. The carrying out of these recommendations is left to the agency or the person referring the case, except where the emotional disturbance is so deep-seated that psychiatric treatments are called for. In such cases, whenever possible, arrangements are made to have the patient returned to successive clinics to receive these treatments. In general, therefore, mental hygiene clinics in this state are chiefly diagnostic, though some treatment is undertaken in special cases.

Cases are referred to the clinics by county departments of public welfare, by private agencies in the community, by schools, by courts, by local physicians, by parents or other

interested individuals and, in some cases, by the patient himself. When the person or agency referring a patient has no facilities for preparing a social case history, such a history is prepared by the clinic social worker.

Roughly 70 per cent of the patients who come to these clinics are children. Among them are children who have become problems in school, either because of behavior or because of educational difficulties; there are delinquent children, referred by the courts or by parents; there are cases of problem homes and problem parents adversely affecting the development of children; there are cases turned over by local physicians or public health nurses who feel that further adjustment on a physical level cannot be attained until some adjustment is made at the emotional level; there are cases verging on psychosis, as well as definitely psychotic cases. Table 3 shows the distribution of the types of problems which are brought to the attention of these clinics.

TABLE 3

TYPE OF PROBLEMS REFERRED TO INDIANA'S MENTAL HYGIENE CLINICS

Type	Per Cent
Total	100.00
Placement	22.28
School problems	20.34
Behavior problems	12.84
Delinquency	9.77
Mental deficiency	7.84
Sex irregularity	6.02
Mental disturbance	5.68
Physical illness with accompanying mental disturbance	4.77
Nervousness, hysteria, etc.	3.18
Domestic difficulties	3.07
Speech defects	2.16
Alcoholism	2.05

Services of the Mental Hygiene Clinics

It is difficult to evaluate the results of this clinic service, because as has been pointed out, the clinics are chiefly diagnostic. A system of follow-up reporting has been devised, however, and at stated intervals these reports are requested on every case in order to determine the progress made. A study of these progress reports shows that in approximately half of the cases there was a remission of the problem or some significant improvement. In the remainder of the cases, some improvement was noted in many instances. Of this last group, in a large percentage of the cases, the recommendations were not carried out or it was found impossible to control some situation which had an important bearing on the problem.

Mental Health Education

Another feature of the clinic program is that a definite effort is made to utilize these clinics as an educational center for the dissemination of information on mental health. At each staff conference, persons referring cases, with other interested individuals, are invited to attend. In connection with many of the clinics, advisory committees have been established which serve as centers for imparting information on problems of mental health to key persons in the community. From time to time, members of the clinic teams speak before civic and other groups on various aspects of mental hygiene, and thus an educational program is carried on as a part of the work of the clinics.

Indiana State Advisory Council on Mental Hygiene

Prevention, however, does not begin nor end with those who are already suffering some maladjustment. Mental health should begin with the healthy in mind in order to keep them so. For that reason, this Division has sponsored two groups at the state level, outside of the welfare department. The State Board of Public Welfare has established the Indiana State Advisory Council on Mental Hygiene. This Council is made up of a group of outstanding public-spirited citizens interested in mental health. Its function is to advise the state welfare department on matters pertaining to mental health and to inform the public of the problems involved. On the strength of a recommendation made by the Council, Governor

M. Clifford Townsend invited Dr. Samuel W. Hamilton, mental hospital advisor for the United States Public Health Service, to make a study of the five mental hospitals, the two institutions for the feeble-minded, the Village for Epileptics and the Hospital for Insane Criminals in this state. To date, Dr. Hamilton's report has not been released, but it is expected that it will be available shortly.

The Council, through its legislative committee, has made a study of a number of phases of Indiana's laws dealing with mental cases, and some recommendations on legislative changes are expected to result from this.

Indiana Society for Mental Hygiene

The Division of Medical Care has also sponsored the reorganization of The Indiana Society for Mental Hygiene. This Society was organized in 1916 and carried on an active campaign stimulating interest in problems of mental health until 1936. From 1936 to 1939 the Society ceased to function, although it did not go out of existence. In September, 1939, it was reorganized and the purpose of this new Society was stated to be:

> "To work for the conservation of mental health; for the prevention of mental diseases and mental deficiency and for improvement in the care and treatment of those suffering from nervous or mental disease or mental deficiency."

One activity of the Society was the holding of a two-day annual conference in Indianapolis in May, 1940. Able speakers were brought from various parts of the state as well as from outside the state. The conference was held in conjunction with the observance of "State Institution Week". In addition, a quarterly journal, the *Mental Hygiene Review,* has been published by the Society. Plans are now under way for the next annual conference, when persons trained in special phases of mental hygiene will be brought in to discuss their specialties.

Indiana's Mental Hospitals

INTRODUCTION

Indiana operates five hospitals for the care of the mentally ill. These institutions are strategically located to serve the various sections of the state. That such was the purpose in deciding upon the location of these institutions is indicated by the names which were originally given to them. Richmond State Hospital was formerly known as Eastern Indiana Hospital for the Insane and Madison State Hospital as Southeastern Hospital for the Insane, while the institution formerly known as Central Indiana Hospital for the Insane still has its location indicated in its present name of Central State Hospital.

The capacity and the population of these hospitals as of June 30, 1940, are shown in Table 4.

TABLE 4

CAPACITY AND POPULATION OF INDIANA STATE HOSPITALS
JUNE 30, 1940

Institution	Capacity	Population
Total	8,448	8,433
Central State Hospital	2,141	2,090
Logansport State Hospital	2,027	1,939
Richmond State Hospital	1,500	1,629
Evansville State Hospital	1,200	1,199
Madison State Hospital	1,580	1,576

It should be noted that the capacity of several of these institutions has been increased since the close of the fiscal year because of the opening of some new buildings. The average daily population of all mental hospitals during the 1939-40 fiscal year was 8,323 patients.

Indiana had an investment, at the close of the last fiscal year, of over 13½ million dollars in these five institutions. Table 5 shows the value of land, buildings and equipment at these institutions.

TABLE 5

INVENTORY OF INDIANA STATE HOSPITALS

JUNE 30, 1940

Institution	Total	Land	Buildings	Equipment and Supplies
Total	$13,629,189.55	$1,083,217.03	$10,455,663.47	$2,080,309.05
Central State Hospital	4,154,929.07	360,000.00	3,033,000.00	761,929.07
Logansport State Hospital	2,843,680.64	180,935.71	2,108,421.29	554,323.64
Richmond State Hospital	2,458,464.50	137,596.25	2,049,550.79	271,317.46
Evansville State Hospital	1,830,575.17	280,930.07	1,388,798.65	160,846.45
Madison State Hospital	2,341,540.17	123,755.00	1,885,892.74	331,892.43

Cost of operating these institutions for the 1939-40 fiscal year was $1,652,580.71, an average per capita cost for current expenses of $198.57. This figure does not take into consideration receipts for individual support paid into the state treasury of $99,705.38, or a per capita of $11.98. If these receipts are deducted from expenditures, this leaves an average net per capita operating cost of $186.59.

Indiana's five state hospitals offer care and treatment to mentally ill residents of the state. Admission is obtained through commitment of the patient by the court. Provision is made for the admission of patients on a voluntary basis, without court action, but only a negligible part of the mental hospital population is received under this procedure.

Release from these institutions is by direct discharge, in cases where the patient has completely recovered, or by furlough. A furlough is a conditional release of the patient to the community. If the patient adjusts successfully, he is discharged, but, should his adjustment be unsatisfactory, he may be returned to the hospital for further care and treatment without the necessity of another court commitment. The right to discharge or furlough patients is vested in the superintendent of the hospital.

CENTRAL STATE HOSPITAL

Central State Hospital is the oldest of Indiana's mental hospitals. An act of the 1844-45 legislature provided for "a suitable site for the erection of a State Lunatic Asylum". Construction was begun on May 5, 1846, and the institution received its first patients on November 21, 1848. From time to time the legislature has increased the capacity of this hospital by addition of new buildings. During the past year a male personnel building has been completed and occupied, and a new cottage, similar in design to other cottages on the grounds, has been completed and put into use.

This is a view of the imposing entrance to one of the new buildings of Central State Hospital, oldest and largest mental institution in Indiana.

Central State Hospital is located in Indianapolis on a 160-acre site. It receives patients of both sexes from the following counties: Boone, Clinton, Hancock, Hamilton, Howard, Marion, Tippecanoe, Tipton and Warren. In addition, it receives female patients from Benton, Carroll, Jasper, Miami, Newton, Wabash and White counties.

As well as being the oldest, this hospital is also the largest of its kind in the state. During the year ending June 30, 1940, its average daily population was 2,036 patients, the highest population in its history.

The old men's building, which is more than 90 years old, is being demolished, and in its place a cottage-type building has been erected. While Central State Hospital now has five of these modern buildings, many of its buildings are old and the style of their architecture does not lend itself readily to modernization.

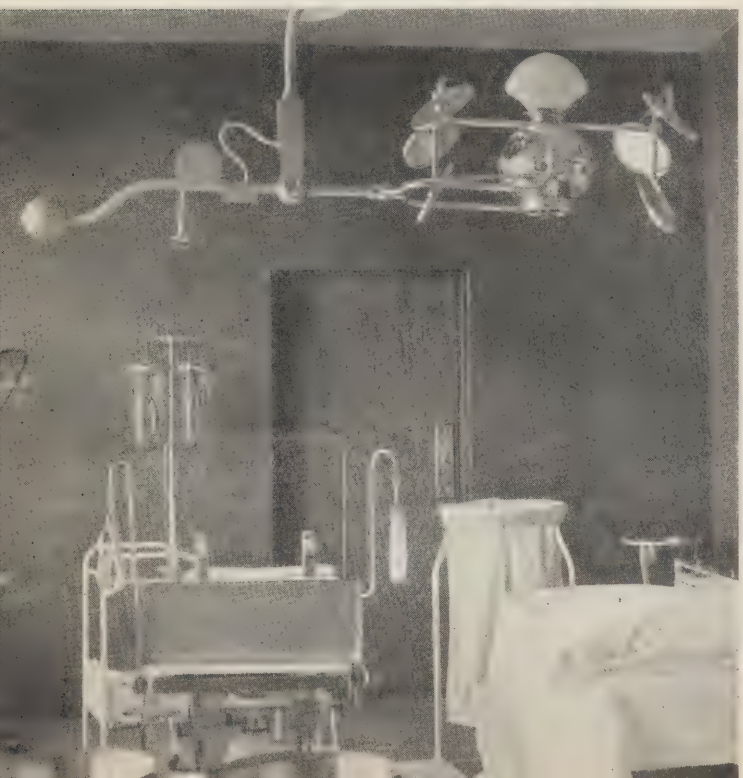
RICHMOND STATE HOSPITAL

Richmond State Hospital was one of the three mental hospitals authorized by the legislature in 1883. Some of the buildings were completed and occupied by the School for Feeble-Minded Youth in 1887. This school was moved to Fort Wayne on July 8, 1890, and on August 4, 1890, the first patient was admitted to the hospital for the insane.

This hospital is located in Richmond and occupies a site of 1,100 acres. During the past year a new auditorium was completed, which is so constructed that it serves as an auditorium in which religious services are held, as well as other social functions, and as a gymnasium for the patients. The second floor of the medical building was remodeled and made into offices for the physicians. The cold storage building was remodeled and a new milkhouse was constructed.

Richmond State Hospital serves the following counties: Adams, Allen, Blackford, DeKalb, Delaware, Fayette, Grant, Henry, Huntington, Jay, LaGrange, Madison, Noble, Randolph, Rush, Steuben, Union, Wayne, Wells and Whitley.

During the year ending June 30, 1940, the average daily population of this hospital was 1,627 patients.



The new surgery at Richmond State Hospital.

Since occupational therapy is a valuable part of any mental hospital treatment program, patients at Logansport State Hospital are encouraged to engage in useful tasks. This woman is busy at a loom. Much of their crafts work is startlingly beautiful; all has therapeutic value.

LOGANSPORT STATE HOSPITAL

In 1883 the legislature provided for the location and erection of three additional hospitals for the insane. Logansport State Hospital was the first of these three to be completed and occupied as a mental hospital. The hospital was opened for the reception of patients on July 1, 1888.

Located one and one-half miles west of Logansport, the hospital occupies a site consisting of 909 acres of land. During the past year four new buildings have been completed: a medical and surgical unit, a hydrotherapy and X-ray unit, a male infirmary building and a women's ward. These new buildings have done much to relieve the overcrowded condition which existed for years at this hospital.

This hospital receives patients of both sexes from the following counties: Cass, Elkhart, Fulton, Kosciusko, Lake, LaPorte, Marshall, Porter, Pulaski, Starke and St. Joseph. In addition, it receives male patients from Benton, Carroll, Jasper, Miami, Newton, Wabash and White counties.

During the year ending June 30, 1940, the average daily population of this institution was 1,897 patients, which, as in the case of Central State Hospital, is the largest population in the history of the institution. This represents an increase over the population of 10 years ago of 35 per cent.

Studies made at this institution show that the average length of residence of patients in this hospital in 1939 was 9.59 years.

Many of the patients whose physical condition permits find agreeable and useful employment in cultivating some of the 879 acres of land which constitute the grounds of Evansville State Hospital. The products contribute largely to the subsistence of the institution, a general view of which is shown above.

EVANSVILLE STATE HOSPITAL

Evansville State Hospital was the third mental hospital authorized by the legislature of 1883. Because of difficulties and delays in construction, the first patients were not admitted until October 30, 1890.

The hospital is located on an 879-acre tract about four miles east of Evansville. The district served by this hospital is comprised of the following counties: Clay, Dubois, Fountain, Gibson, Greene, Knox, Montgomery, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo and Warrick.

During the year a new building was completed and occupied, providing sleeping quarters for 102 employees. The building housing the main kitchen was modernized, and other minor improvements were made.

During the year ending June 30, 1940, the average daily population of this hospital was 1,187 patients. The population of this institution has remained fairly stable over the last five years.

Evansville State Hospital is the only mental hospital in the state operating an outpatient clinic. This clinic is held in downtown Evansville and is utilized by nearby counties as well as by residents of Evansville.

MADISON STATE HOSPITAL

Madison State Hospital was authorized by the legislature on February 21, 1905. It was opened for the reception of patients on August 23, 1910.

The hospital is located on a plateau 400 feet above the Ohio River and about one and one-half miles from North Madison. It consists of 30 buildings located on a 1,234-acre site. The district served by this institution is comprised of the following counties: Bartholomew, Brown, Clark, Crawford, Daviess, Dearborn, Decatur, Floyd, Franklin, Harrison, Hendricks, Jackson, Jefferson, Jennings, Johnson, Lawrence, Martin, Monroe, Morgan, Ohio, Orange, Ripley, Scott, Shelby, Switzerland and Washington.

During the year ending June 30, 1940, the average daily population of this hospital was 1,577 patients. This is a decrease from 1939 of 100 patients. Capacity of this institution is 1,580 patients. Reduction of population was obtained through some changes in the hospital district, relieving Madison State Hospital somewhat of its overcrowded condition. No new buildings were constructed at this institution during the year.

The picture shows the administration building at Madison State Hospital, last of the five institutions established by the state for the care and treatment of mental cases. Each year a fair number of patients are discharged as improved or recovered. The fever treatment is used in cases of general paresis and the institution has used hydrotherapy with success.

Indiana's Institutions for the Feeble-Minded

INTRODUCTION

Indiana operates two institutions for the care and training of the feeble-minded, the one serving the counties in the northern half of the state and the other serving counties in the southern half of the state. The capacity and population of these two institutions as of June 30, 1940, are shown in Table 6.

TABLE 6

INSTITUTIONS FOR THE FEEBLE-MINDED
CAPACITY AND POPULATION
JUNE 30, 1940

Institution	Capacity	Population
Total	2,801	2,851
Fort Wayne State School	1,900	1,966
Muscatatuck Colony	901	885

The daily average population of these two institutions during the 1939-40 fiscal year was 2,815 patients. Since this is an average figure and since Muscatatuck Colony was expanding during the year, this figure is not representative. The population present on June 30, 1940, was 2,851 and even this figure is low, because new buildings have been completed and occupied since the close of the fiscal year.

At the close of the last fiscal year, Indiana had an investment in these two institutions of almost five million dollars. Table 7 shows the value of land, buildings and equipment at these institutions.

TABLE 7

INSTITUTIONS FOR THE FEEBLE-MINDED
INVENTORY, JUNE 30, 1940

Institution	Total	Land	Buildings	Equipment and Supplies
Total	$4,911,609.42	$911,607.90	$3,589,178.38	$410,823.14
Fort Wayne State School	2,187,358.49	773,271.70	1,183,478.38	230,608.41
Muscatatuck Colony	2,724,250.93	138,336.20	2,405,700.00	180,214.73

The cost of operating these institutions for the 1939-40 fiscal year was $614,498.33, an average per capita cost for current expenses of $218.33. This figure does not take into consideration receipts for individual support paid into the state treasury of $11,483.46, or a per capita of $4.08. If these receipts are deducted from expenditures, this leaves an average net per capita operating cost of $214.25.

The purpose of these institutions is to provide education and training for the feeble-minded of the state and also to provide custodial care for such cases as cannot benefit by education or training.

Admission is obtained through commitment by the judge of the Circuit Court upon petition of any reputable person in the county. Feeble-minded persons six years of age and over may be admitted, provided they are bona fide residents of the state.

FORT WAYNE STATE SCHOOL

Fort Wayne State School was first organized in 1879 as an adjunct of the Soldiers' and Sailors' Orphans' Home at Knightstown. It was given independent existence in 1887 and construction was started on the present site in Fort Wayne. Before these buildings were completed, a fire at Knightstown necessitated caring for the feeble-minded children in buildings completed for the Eastern Indiana Hospital for the Insane at Richmond. In July, 1890, buildings were completed at Fort Wayne, and the new institution was opened by the transfer of 300 patients from Richmond.

The school is located in Fort Wayne on 54 acres of land. In the vicinity are 849 acres of land owned and cultivated by the school. This school serves the northern half of the state, receiving patients from 43 counties. Chart III on page 23 shows the counties served.

During the year ending June 30, 1940, the average daily population of this institution was 1,948 patients. Population has increased each year since the establishment of the school and is directly related to the capacity of the institution, since the institution is usually filled to capacity. The normal capacity of this school on June 30, 1940, was 1,900 patients.

The school department of the institution was established in 1891 and has operated ever since as an educational unit. This department affords instruction in the following subjects: kindergarten, primary academic, advanced academic, domestic science, wood and metal, physical education, sense training, sewing, basketry, weaving, piano, voice, violin, orchestra, boys' band and drum corps. The industrial departments offer training in the following industries: for boys—shoemaking, tailoring, carpentry, woodworking, painting, printing, broom, mop, and brush making, mattress making, baking, meat cutting, dairying, poultry raising, and general farm work; for girls—kitchen training, dining room work, loom weaving, general housecleaning, beauty parlor, occupational therapy, bed making and assisting nurses in care of the ill.

Under the teacher's close supervision, two members of a boys' academic class at the Fort Wayne State School work on a geography unit.

MUSCATATUCK COLONY

Muscatatuck Colony was originally established in 1920. In 1925 the legislature transferred jurisdiction of the Colony to Fort Wayne State School, and it was operated as an adjunct of that institution until July 1, 1937, when it was established as an independent institution.

Beds for the feeble-minded at Muscatatuck Colony make a study in black and white.

Located about six miles east of North Vernon, the mail address of the Colony is Butlerville. The site of the institution contains 2,071 acres.

In 1937 an extensive building program was started looking toward the expansion of the Colony into a school for the feeble-minded comparable to the Fort Wayne State School. Prior to this time, the Colony had been utilized as a custodial institution for housing males over 16 years of age. This building program was completed in 1940, and the institution now serves the same function as the Fort Wayne State School for residents of the southern half of the state. Chart III on page 23 shows the counties served by this institution. The major building program included the construction of 24 new buildings and a large dam. This program was undertaken to provide adequate housing and facilities for the care of approximately 1,400 feeble-minded patients.

The school department of the institution was opened during the year, and all trainable children are receiving instruction. A well-rounded program of training is under development, and it is anticipated that both in equipment and program this will be one of the most modern institutions of its kind in the country.

Indiana Village for Epileptics

INDIANA VILLAGE FOR EPILEPTICS

The Village for Epileptics was established by legislative enactment in 1905. Male patients were first admitted in 1907 and female patients in 1925. Indiana was, therefore, one of the earliest states to make provision for the separate care of its epileptics, there being very few institutions of its kind in this country at the time the Indiana Village was established.

Patients helped with the construction of this new administration building at the Indiana Village for Epileptics. Improvements were also made on the grounds, including the addition of walks and curbs.

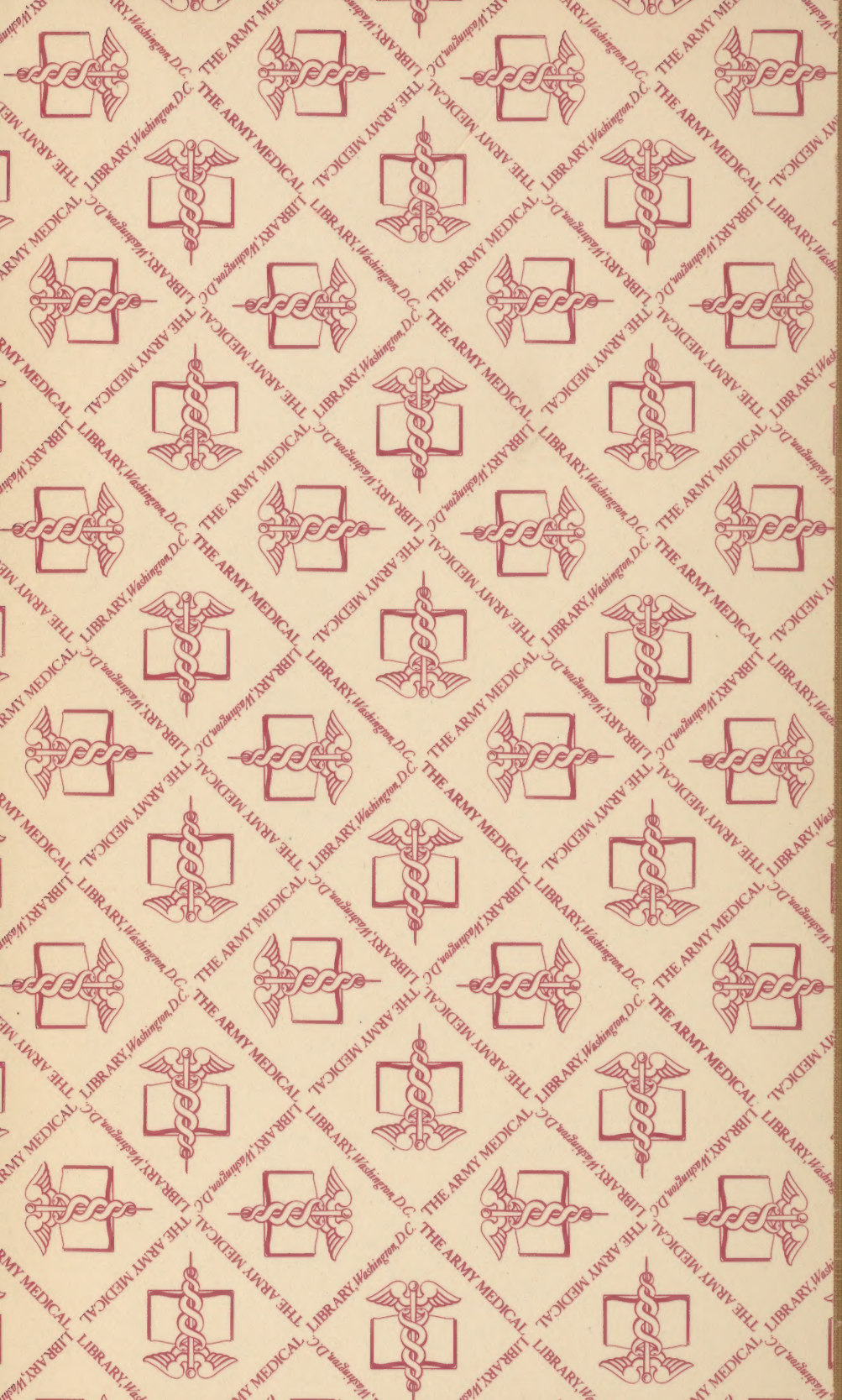
The Village is located on a 1,334-acre tract three miles north of New Castle. As the name indicates, it is constructed on the "village" plan, with the entire institution made up of small units for the segregation of age groups, sexes and types of patients.

From time to time additions have been made to this institution. The Village was planned for an ultimate minimum capacity of 1,250 patients, but, by the addition of one or two buildings in each group, the capacity may be increased to 1,500 or 1,800 without altering the general plan. The Village has grown very slowly to its present capacity of 915 patients.

During the past year, construction carried to completion included a new administration building, two brick cottages for physicians and a men's infirmary building with a normal capacity of 120 patients. Most of the work on these buildings, with the exception of the bricklaying, sheet metal, plastering and tile work, was done by the patients. In addition, a new 300 k.w. turbine generator was installed, a 150,000-gallon steel water tank and a 140-foot steel tower for the tank, were erected.

On June 30, 1940, the population of this institution was 931 patients. Average daily population for the year was 926 patients. Total value of the land, buildings and equipment as of June 30, 1940, was shown by the inventory to be $2,159,813.86. Total cost of operation for the year was $236,735.38, a per capita operating cost of $255.78.

Purpose of this institution is the care and treatment of residents of the state suffering from epilepsy. Admission to the Village is obtained through commitment by the Circuit Court. Petitions for commitment may be filed by relatives or any responsible person living in the same county. This institution serves the entire state. Patients are discharged when in the judgment of the superintendent their mental and physical condition justifies it. Selected patients are released on visit to relatives who are able and willing to accept responsibility for their care.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